NC DIVISION OF MH/DD/SAS
Residential Treatment/PRTF Medicaid Services Audit
2007/2008

AUDITOR INSTRUCTIONS

Protocol for selecting a sample:

- All events for the Medicaid Services audit will be drawn from **paid claims dates of October 1, 2007 – Jan. 31, 2008.**
- **Service dates** will be randomly drawn from **July 1, 2007 – Jan. 31, 2008.**
- **Fifteen (15) primary and five (5) backup** service dates per Residential Treatment Services/PRTF provider will make up the sample, for a total of 20 service event dates.
- If the provider identified documentation deficiencies and paid back the event to Medicaid prior to the date the list of records to be audited was sent to the provider, do not include the event in the audit.
    - Enter "8" in each rating box on the tool, and write "Exclude" on the top of the tool. DO NOT DISCARD.
    - Explain in the comments section of the audit form why the "8" ratings were used and attach a copy of documentation confirming the date and amount of the payback.
    - Replace the excluded tool with the first/next numbered tool from the alternates (start with #16). Alternate tools *must be used in order*.
- **If an item is identified as out of compliance and DMA requires no payback *for the specific reason it was called out of compliance*, or the item does not relate to a DMA requirement, rate the item as "2" rather than "0". *For this audit, this option is available only for questions # 1, 2, 3, 8, 9b. Team leaders will have full information on using the rating "2".***

HEADINGS

The following information needs to be handwritten on the audit tool:

- **Audit Date**
- **Record #**
- **CS Provider 2:** If the author of the PCP is from a different agency than noted in CS Provider 1, enter that name here.
- **CS Other Info:** Attempt to determine provider location (city) and/or *preferably* the provider #, or other information to help identify the specific CS provider site. Enter that information here. Team leaders will have a database where additional provider information may be researched.

MEDICAID AUDIT QUESTIONS

Q1 – Service Authorization:

- All services must be authorized by ValueOptions (VO)
- If the provider does not have evidence of authorization from VO, check for service authorization that covers the date of service being reviewed on the spreadsheet provided by VO. (The spreadsheet will be available on laptops at the team leader table.)
- **Ratings –** In addition to the standard ratings, a rating of "2" may be used for this question.
- **Q1a – Dates: This section must be completed for a rating of "0", but not for a rating of "2".** *FROM* is the first date there was no valid service authorization, *TO* is the last date before the service was authorized or the date of the audit if still not authorized.

Q2 – Service Order / CON for PRTF

- **Service Orders for Level II Program, Level III, Level IV:**
    - Appropriate service has been ordered. **The level of residential treatment service needs to be identified in the body of the PCP to be ordered via signature on the PCP.** Separate service order forms are not acceptable.
    - A service order may not be obtained (signature on the PCP) before the PCP is completed. **Service order signatures dated prior to the PCP date are not acceptable as service orders.**
    - As of the first use of the new PCP format on or after 6/1/06, Medicaid-funded services must be ordered by a licensed MD or DO, a licensed psychologist, a licensed nurse practitioner or a licensed physician's assistant.
        - The signature must be handwritten by the signatory. A stamped signature is only acceptable with a verified Americans with Disabilities Act (ADA) exception.
        - Per the PCP Manual, effective 7/15/07, the signature is verified when the person signing enters the date next to his/her name.
    - When the PCP is reviewed/updated, but no new service is the result, the signature for the service order is not required unless it is time for the annual review of medical necessity.
    - Order is signed on or before the date of service.
    - **Multiple levels of service may not be ordered / listed for the same time period in the PCP.** If they are, the only valid order is the one for the service level the child was actually admitted to.
    - **A new service order must be obtained at any time a child changes the level of residential treatment to which they are admitted, even if returning to a former level.**
    - Example: If a child goes from Level III to Level II, a Level II order is needed at the time of the change. If that same child then goes back to Level III later, a NEW order is needed for Level III.
- **CON (Certificate of Need) for PRTF:**
    - Certifies ambulatory care resources available within the community are insufficient to meet treatment needs of the recipient, AND
    - The child's condition is such that s(he) requires services on an inpatient basis under the direction of the board eligible/certified child and adolescent

psychiatrist or general psychiatrist with experience in treating children and adolescents, AND
    - The services can reasonably be expected to improve the recipients' presenting condition or prevent further regression so that services will no longer be needed.
    - Effective date for a CON is the LAST date of the required signatures on the standard form.
- **Ratings –** In addition to the standard ratings, a rating of "2" may be used for this question.

Q3 – PCP is Current:

- The individualized PCP shall begin at admission and shall be updated/revised:
    - If the needs of the person have changed (i.e., new service is being requested; existing service is being reduced or terminated and goals need to be revised, added or terminated; a significant event has occurred in the person's life requiring review of goals, etc.)
    - On or before assigned target dates
    - When a provider changes
- **Introductory PCP**
    - For use **only for a person who is new to the mh/dd/sa system or who has been completely discharged for 60 days with no services.**
    - In Residential Treatment/PRTF, the Intro PCP may only be completed by the Community Support provider QP.
    - Even though the CS services do not need pre-authorization from VO while the Intro PCP is developed, any other services provided, including residential treatment/PRTF does require authorization.
    - The Intro PCP consists of:
        - Action Plan page(s)
        - Crisis Prevention/Crisis Response page(s)
        - Signature page
    - The Intro PCP is valid for whatever period of time is authorized for services by VO, after submission of the Intro PCP, usually no more than 90 days.
- **Complete PCP**
    - We are most likely to see only Complete PCPs for residential treatment/PRTF services.
    - The Complete PCP must be submitted to VO prior to the end of the first authorization period for additional authorization to occur (if initial residential authorization occurred under an Intro PCP).
    - In Residential Treatment/PRTF, the Complete PCP may only be completed by the Community Support provider QP.
    - **There may be no separate PCPs** written for residential treatment/PRTF services.
    - All sections of the PCP are required for the Complete PCP:
        - Participants in Plan Development
        - 3 Interview sections
        - Summary of Assessments and Observations
        - Actions Plan
        - Crisis Prevention/Crisis Response
        - Comments and Signatures

- **The current PCP format which created the Intro PCP and Complete PCP was effective for use on 7/15/07, and was revised on 9/26/07.**
    - **Beginning 7/15/07, existing PCPs had to be transferred to the new Complete PCP format at the next revision or the annual medical necessity review.**
    - As of 9/27/07, transfer to the Complete PCP as above should occur on the current format now posted on the web.
    - The previous version of the PCP was effective from 8/1/06 – 7/14/07.
    - **If a PCP being reviewed does not appear to be on the correct form, consult with a Team Leader regarding the appropriate compliance call to make.**
- The Complete PCP must be rewritten annually. This will most often be done at the same time as the annual review for medical necessity.
- Target dates may not exceed 12 months.
- **Signatures:**
    - Author of the PCP and legally responsible person have signed the PCP (documented explanation if not signed or signed later). Signatures must be dated on or before the date of service.
        - Child's signature alone is OK when an emergency admission to 24 hr. facility and the legally responsible person isn't present, and the child is MI or SA and in need of treatment (GS 122C-223(a).
        - Per above, within 24 hrs. of admission, legally responsible person must be notified and unless that notification is impossible, legally responsible person is required to sign the plan [GS 122C-223(b)].
        - Per above, if legally responsible person is not located within 72 hours of admission, responsible professional must initiate protective services and the protective services representative must sign the plan (GS 122C-223).
    - Signatures of the person to whom the plan belongs (or legally responsible party) and the person who wrote the plan (CS QP) are obtained for each required/completed review, even if no change occurred.
    - Signature verifying medical necessity (a service order) is required only if the result of an interim review is the addition of a new service, unless the review is the annual review of medical necessity.
- Documentation of the legally responsible person, if not the parent of a minor, needs to be reviewed, i.e., court ordered guardianship, court-appointed custody to DSS.
    - If a minor is cared for by someone other than a parent, and evidence of that caretaker having the intention for long-term care is present, that may be accepted as “in loco parentis” in lieu of legal guardianship.
    - Check with Team Leader before accepting “in loco parentis”.
- **Ratings –** In addition to the standard ratings, a rating of “2” may be used for this question.

Q4 – Documentation is Signed:

- Service note is signed by the person who provided the service, on all shifts (no initials).
    - If signature reads, "G. Walton", rate as "1". Make a recommendation to correct (full name required) in the Summary of Findings if this is a single or occasional error. Require a POC if this is an agency-wide problem.
    - If signature reads, "Jeff H.", rate as "0".
    - If first name only is present, i.e., "Patricia", rate as "0".
    - If signature reads, "B.J.", rate as "0".
- Signature includes credentials, license, or degree for professionals; position name for paraprofessionals.
    - The credentials/license/degree/position do not have to be handwritten. They may for example, be typed, or stamped.
    - The signature must be handwritten unless there is an ADA documented modification.
- As of 1/1/08, per the RMDM, service notes must be *written* and signed by the person who provided the service.
- If the signature does not include the credential, license, degree or position, rate this "1". If it is a single or occasional error, make a recommendation for inclusion in the Summary of Findings. If it is a systemic problem, require a POC.
- **If there is no service documentation for the date being reviewed, mark this question "6 = No service note". Also mark "6" for Qs 5, 6, 10.**

Q5 – Service Note reflects Purpose of Contact, Staff Intervention, Assessment of Progress toward Goals

- If the intervention relates only to daily living skills, review service notes around the service date audited to determine if notes relate to the treatment goals. There must be evidence of documentation by residential staff on treatment goals to call this question in compliance. (If unsure, consult a team leader.)
- Minimal documentation is a full narrative service note per shift for Level III, IV, & PRTF. A service log may be used for Level II.
- Service note can be in any format but must include:
    - **Purpose** of the contact as it relates to a goal statement in the service note. The purpose can be documented by quoting a full goal, paraphrasing a goal, and/or indicating the corresponding goal number.
    - **Description of the interventions(s)** / activity / treatment (what the staff member did).
    - **Assessment of person's progress toward goals** / effectiveness for the individual.
- Each shift note for the 24 hour period must include all three elements for Q5 to be in compliance.
- If the child is on Therapeutic Leave (not counted in the midnight census) a minimal note is requiring referencing therapeutic leave.
- At a minimum, one note per shift is required. Auditors must identify what the providers' shifts are. All 24 hours must be accounted for.
- **If Q5 is rated "0" for *intervention – meaning there was none documented*, Q10 is also rated "0".**

Q6 – Service Note Relates to Goals:

- Service note states, summarizes and/or relates to a goal or references a goal number in the PCP.
- The goal has not expired and is not overdue for review.
- If the child was on therapeutic leave on the service date being audited, the PCP must include Therapeutic Leave as a goal or strategy which includes the necessity for such leave and the expectations involved in such leave.

Q7 – Service Definition/Rule Requirements:

- **Specific questions for each level of service are:**
  - **Level II Program:** Was clinical consultation provided by a qualified professional to this facility at least twice a month?
  - **Level III & Level IV:** Was consultative & treatment service at a qualified professional level available at levels defined by the service definitions? (4 hrs/week for Level III; 8 hrs/week for Level IV)
  - **PRTF:** Did the psychiatrist provide weekly consultation to review medications with this child/adolescent?
- Ask for evidence that the required consultation/treatment service at a qualified professional level was available/provided at the required level. Evidence could include, program schedules, service notes, group counseling schedules, etc.
- **Q7a – Days:** If NOT MET, list program / work days for **Level III, Level IV and PRTF** (i.e. Mon. – Sun., Sun – Sat.) Do not complete for Level II Program.
- **Q7b – Dates:** If NOT MET, list actual dates of program / work week or month for Level II Program, that are out of compliance, i.e. *FROM* 7/3/07, *TO* 7/9/07.
- *Individual or group psychotherapy provided by another provider can only be counted toward the required hours if the Residential provider is paying for the service. The required consultation hours are included in the residential rates.*

Q8 – Licensed Professional Services – for Level III only

- Ask for evidence that **face-to-face clinical consultation** occurred at least 4 hrs/week in the facility by a licensed professional.
- Consultation shall include:
  - Clinical supervision of the Qualified Professional
  - Individual, group or family therapy, or
  - Involvement in child/adolescent specific treatment plan or overall program issues
- **Rate this question NA for Level II Program, Level IV and PRTF.**
- **Ratings –** In addition to the standard ratings, a rating of "2" may be used for this question.

Q9 - Service Notes and PCP are Individualized:

- **Q9a**: Review service notes around the service date audited to determine if notes are individualized. Recommend reviewing at least one week on either side of the event date.
  - Notes should vary from day to day and person to person, and be specific to goals in each PCP.

    - The first record reviewed may have to be revisited if consequent notes in another record appear to be the same.
- **Q9b**: PCPs and goals/interventions in particular, should be individual to the person to whom the PCP belongs.
    - If the Goals are the same from one PCP to another, review the strategies/interventions, with the expectation of finding differences. Children/adolescents may have similar goals, but the manner of addressing them should be individual from child to child.
- **Ratings – Use only the 9a and 9b boxes for ratings. There is no overall rating for Q9.** Put an "X" or "N/A" in the overall rating box on the audit tool.
- **Rating 9a**
    - If there was no note for this date of service, rate 9a = "9". ***There is no other use of "9" for Q9a.***
- **Rating 9b -** In addition to the standard ratings, a rating of "2" may be used for this question.

Q10 – Documentation Reflects Treatment for the Duration of Service:

- The treatment documented reasonably appears to have taken place in the time stated.
- The intervention reflects "treatment", not only activities of daily living (ADLs), chores, etc. for the time indicted.
    - If the intervention relates only to daily living skills, review service notes around the service date audited to determine if notes relate to the treatment goals. It may be fine to have documentation one given date relate only to ADLs as long as there is plenty of evidence of "treatment" in documentation on other dates before and after. (If unsure, consult a team leader.)
- If Q5 is rated "0" for *intervention*, then this question is automatically found out of compliance as well.

Q11 – Qualifications/Training:

- Provider of service is qualified in accordance with State rules.
- **If child/adolescent is at risk for sexual offending (look at PCP / goals / diagnoses) special training of the staff is required in all aspects of sex offender specific treatment.**
- The paraprofessional service provider has a high school diploma or GED, and all qualifications are in place on or before the date of service.
- Qualifications not expired.
- Alternatives to Restrictive Interventions training:
    - Auditors will have a list of State approved Alternatives to Restrictive Interventions curricula.
    - Ask what training program the provider uses and compare to list of approved curricula.
    - The initial training or an update must have occurred within one year prior to the date of service being reviewed.
    - In order to consider this training in compliance, **all staff who signed shift notes on the date reviewed** must have received training within one year of the date of service.
- If service note is not signed or missing, rate Q11 as "7/provider name not available".

- **Use the Qualifications Check Sheet included in your audit packet while checking for credentials/training.**
    - For CPR and First Aid, one person working each shift must have the training.
    - If staff reviewed is not trained in CPR or First Aid, determine if any other staff worked and if they had the training.
    - If any staff on shift was trained, do not call qualifications out of compliance.
- **Q11a – Dates: This section must be completed for a rating of "0", but not for a rating of "2".** *FROM* is the first date service was provided when staff was not qualified, *TO* is the last date before the staff became qualified or the date of the audit if still not qualified.

Q12 – Supervision Plans:

- Individualized supervision plans are required for paraprofessionals and associate professionals.
- **Q12a:** Review each supervision plan to determine frequency/duration of required supervision. If supervision plan is in place, rate Q12a = "1".
- An agency policy on supervision, even if it includes frequency/duration of supervision may not be accepted in lieu of an individual supervision plan.
- **Q12b:** Supervision plans must be implemented as written. Review documentation of supervision against the supervision plan requirements. If supervision plan was implemented as written, rate Q12b = "1".
- Evidence of the implementation of supervision plans could include such things as notes or logs kept by the supervisor of group and/or individual supervision meetings.
- Any documentation accepted must include at a minimum, the name of the staff person and indicate the date of the supervision and the duration of the meeting, if duration is specified in the supervision plan.
- Standard staff meetings are not considered "supervision".
- **Q12c – Dates:** If there is no supervision plan or it is not implemented as written, enter the dates of non-compliance in 12c, for example:
    - If there is no supervision plan, FROM is the date of hire or 7/1/07, whichever is later, and TO is the day before a supervision plan was in place or the date of the audit. For example: FROM: Oct. 18, 2007 *(date of hire)* TO: April 28, 2008 *(date of audit).*
    - If there is a supervision plan but no evidence it was implemented, enter the dates of non-compliance in 12c. For example:
        - Supervision plan calls for 1/month supervision. Event date is Sept. 12. Enter "*FROM*: Sept. 1 *TO*: Sept 30, 2007" in 12c.
        - Supervision plan calls for 1/week supervision. Event date is Sept. 12. Ask what the work week is (i.e., Monday-Sunday). Look up corresponding dates for the week and enter in 12c.
    - If there is a supervision plan but no frequency is indicated, the default for audit purposes in one month. Enter the dates of the month for the date of service reviewed. For example, if date of service is 8/19/2007, FROM: 8/2/07, TO: 8/31/07.
- **Overall Rating:** Both Q12a and Q12b must be rated "1" to have an overall rating of "1" for Q12.

Q13 – Criminal Record Disclosure and/or Criminal Record Check (CRC)

- **Q13a – Criminal Record Disclosure *for staff hired prior to 3/24/05*:**
  - Determine date of hire.
  - Auditor will request from service provider, any documentation that indicates the agency requested the required disclosure prior to employment.
  - Most likely to see on employment applications, or on documentation from interview.
- **Q13b – Criminal Record Check *for staff hired on or after 3/24/05*:**
  - Determine date of hire.
  - No criminal history record checks required for applicants that have an occupational license, i.e. MSW, MD, Nurse, etc.
  - For an applicant who had been a resident of NC for **less than five (5) years**, he/she must have **consented to a State and National** record check before conditional employment.
  - For an applicant who had been a resident of NC **for five (5) years or more**, he/she must have **consented to a State** record check before conditional employment.
  - The provider, within five (5) business days of making a conditional offer for employment, must submit a request to the Dept. of Justice to conduct a criminal record check. A NC county or company with access to the Division of Criminal Information (DCI) data bank may conduct the record check on behalf of the provider.
  - **Most often providers will show auditors the actual criminal record check results. HOWEVER, to be in compliance with this requirement the auditor need only see the applicants consent for a CRC or the auditor may see the provider's request for a CRC. We do not need to see the results.**
  - ***For purposes of the audit, the criminal record disclosure or consent to or request for a CRC must have occurred prior to the date of service reviewed.***
- **Q13c – Dates:** If the disclosure or consent or request for Criminal Record Check was not completed prior to the date of service, enter the dates in Q13c. *FROM* is the date of hire or 7/1/07, (whichever is later), *TO* is the last date before the disclosure or consent or request for the record check was completed, or the date of audit if not yet completed.

Q14 – Health Care Registry Personnel Check

- There may be **no substantiated finding of abuse or neglect** listed on the NC Health Care Personnel Registry.
- Health Care Personnel Registry check must have been completed prior to the date of service.
- **Q14a – Dates:** *FROM* is the date of the finding noted on the HCPR, or 7/1/07 if the check was not completed prior to the date of service. *TO* is the last date before the HCPR check was completed or the date of the audit if not yet completed.

Comment Section:

- Ensure that a good explanation is included in the comment section for any item called out of compliance.
- **Attach copies of documentation to support the findings and the written explanation.**
- Note and make recommendations regarding other PCP or service note deficiencies that are out of compliance with DHHS rules other than the Medicaid required criteria above.

Additional Information:

- Review all tools for completion, accuracy, and attachment of supporting documentation.
- The provider being audited should not leave the audit site with their records before the completed audit tools are reviewed by a Team Leader.
- Make copies of the audit tools for the provider. Let provider know all areas found out of compliance and of any POCs that will be required.
- Remind providers that the copies of the audit tools do not necessarily represent the final, formal results of the audit. Changes could be made after a later Team Leader review or other State findings. Final findings will be represented in the formal Summary of Findings report that they receive by mail and which will be accompanied by any DMA information regarding sanctions.